

**Usefulness of combining intermittent hypoxia and physical exercise in the treatment of obesity**

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## **Summary**

Obesity is an important public health problem worldwide and is a major risk factor for a number of chronic diseases such as type 2 diabetes, adverse cardiovascular events and metabolic syndrome related features. Different treatments have been applied to tackle body fat accumulation and its associated clinical manifestations. Often, relevant weight loss is achieved during the first six months under different dietary treatments. From this point, a plateau is reached, and a gradual recovery of the lost weight may occur. Therefore, new research approaches are being investigated to assure weight maintenance.

Pioneering investigations have reported that oxygen variations in organic systems may produce changes in body composition. Possible applications of intermittent hypoxia to promote health and in various pathophysiological states have been reported.

The hypoxic stimulus in addition to diet and exercise can be an interesting approach to lose weight, by inducing higher basal noradrenalin levels and other metabolic changes whose mechanisms are still unclear. Indeed, hypoxic situations increase the diameter of arterioles, produce peripheral vasodilatation and decrease arterial blood pressure. Furthermore, hypoxic training increases the activity of glycolytic enzymes, enhancing the number of mitochondria and glucose transporter GLUT-4 levels as well as improving insulin sensitivity. Moreover, hypoxia increases blood serotonin, decreases leptin levels while appetite is suppressed. These observations allow considering the hypothesis that intermittent hypoxia induces fat loss and may ameliorate cardiovascular health, which might be of interest for the treatment of obesity. This new strategy may be useful and practical for clinical applications in obese patients.

**Key Words:** obesity, body weight loss, intermittent hypoxia, treatment.

## **1. Obesity: Prevalence, causes and complications**

Obesity is an important public health problem in most countries [63], which is characterized by an excess of body fat, when amounting values higher than 20% in men and 30% in adult women [20, 66]. The World Health Organization (2009) warns that there are over 400 million obese adults, and that the situation will worsen in the future.

The main etiological factors causing excess body weight for height are assigned to overeating and low physical activity, which lead to a positive energy balance, and result in a body fat increase [91]. Furthermore, there are other causes such as the genetic component, the distribution of energy intake throughout the day, the dietary composition of macronutrients, sleep rest, endocrine disruptions or the individual ability to oxidize energy substrates [26, 70, 93]. Thus, obesity is a chronic multifactorial disease resulting from the interaction between genotype, environment and physical activity patterns [14, 91, 95].

Obesity is considered one of the major risk factors in the onset of associated chronic diseases, such as hypercholesterolemia, type II diabetes (T2D), cardiovascular disorders and metabolic syndrome features [101]. On the other hand, the higher BMI and waist circumference are, the greater is the relative risk of comorbidities [118]. Indeed, obesity has become the second leading cause of premature and evitable death, just after tobacco [14, 49].

## **2. Treatments for obesity: diet, exercise, pharmacology and bariatric surgery**

Low-calorie diets, programmes of physical activity (typically aerobic) and behavioural therapy are common strategies to lose weight in the obese patient [121]. These type of interventions are often the first step in any therapeutic approach to treat obesity. In general, it should be tested at least for six months before considering the introduction of any other therapeutic strategy [79]. The needs and characteristics of a treatment against obesity will be determined regarding the estimated risk in the obese patient and according to clinical criteria for therapeutic intervention [53]. Additionally, there are interindividual differences in the response to different dietetic interventions or to physical exercise due to the genetic predisposition [90]. Thus, some attempts to set out differences depending on the genotype have been reported, although the information about the treatment success is relatively poor.

Other therapeutic approaches have been applied to induce weight loss, which may include exercise, psychological support, drug therapy and at last, surgery treatment [50], being the first two also prevention strategies. Therefore, long-term approaches to maintain weight loss are still sought.

Generally speaking, weight losses are achieved during the first six months of treatment. From this point a plateau is often reached, and a gradual recovery of the lost weight commonly occurs [39]. This outcome is facilitated by the fact that adherence to the diet and physical activity often declines and also due to a possible metabolic adaptation [10], therefore long-lasting therapies are being searched.

### ***2.1 Dietetic and nutritional treatments***

The most common treatment guidelines for obesity, currently in use, are dietary and nutritional approaches [1]. The restriction should not result in a caloric intake below 1.000-1.200 kcal / day in women and 1200-1600 kcal/day in men (except in case of morbid obesity), since that value is the minimum energy intake, which ensures a balanced intake of micronutrients in the requested amounts [10, 2, 103]. An energy restriction of 500-1000 kcal/day compared to the usual diet results in weight loss of 0.5-1.0 kg/week, which represents an average of 8-10% of initial body weight in 6 months [1]. However, this weight loss is not completely linear [8].

There is some controversy regarding the distribution of macronutrients to be prescribed, being the classical approach, with respect to a 1000-1600 kcal/day, a distribution of 20% proteins, 50% carbohydrates and 25-35% fat [48], although moderate high protein diets (30% energy) can also be applied [80]. Short-term weight reductions have been observed, but weight is regained in the long-term [5]. It seems that one of the causes for the interruption in weight loss is a reduction in basal energy expenditure [106]. Protein intake is maintained high in some cases with the aim of slowing the loss of lean body mass and delaying the stabilization of weight [1, 280]. However, there are several unresolved issues, such as the prescription of moderately high protein diets (20-35% of energy) during the weight maintenance phase or the beneficial effect of some foods with lower glycaemic index or glycaemic load on body weight [2, 80, 144]. Considering high-protein or low-fat diets, it is important to increase the amount of fibre (more than 30g/day) and the monounsaturated fat in order to facilitate the maintenance of a healthy circulating lipid profile [114]. In conclusion, one can notice that adherence is low in many of

the extreme diets, with different proportions of macronutrients, being the cause that in the long-term they are often not effective and obese people need other types of aid [39].

## ***2.2. Physical activity programmes***

Some guidelines state that 60-90 daily minutes of moderate exercise are requested for the treatment of obesity [67]. Traditionally, aerobic exercise has been recommended in order to lose body fat, but recent studies show that strength-endurance exercises (circuits of 6-10 exercises and 10-15 reps, with a frequency of 2-3 times / week) can be more effective, particularly to reduce abdominal fat [60, 97] and visceral adipose tissue [62].

The strength-endurance programmes tend to burn primarily abdominal fat, unlike fasting [141]. They also favour low appetite by stimulating the corticotrophin-releasing hormone [115]. The most effective treatment to improve health parameters as well as body composition appears to be strength training or strength training combined with aerobic endurance training, which seem to improve **both** health biomarkers and to reduce fat content [135, 142, 145].

Since the energy cost of all exercise modes except walking seems to be beneficial, priority should be given to the obese preferences to promote long-term activity behavioral change [137]. Moreover, it is known that physical exercise increases the secretion of endorphins [74], improving mood, and helping the patient to maintain motivation increasing adherence to the treatment.

Strength-resistance training (SRT) is associated with great energy expenditure during the exercise session [30]. Some studies have reported that regular SRT is effective in promoting weight loss in obese subjects, decreasing fat mass and increasing lean body mass and thus has little influence or no effective change in total body weight [59, 120, 132]. SRT prevent the loss of lean body mass, secondary to dietary restriction [134] and reduces exercise-induced oxidative stress and homocysteine, regardless of adiposity [125]. A potential mechanism for this reduction could include contraction-induced antioxidant enzyme up-regulation [139].

Several studies have demonstrated a decrease in visceral adipose tissue after SRT programs [139, 38] which seem to reduce visceral fat depots through both immediate effects (during weight loss and weight maintenance) and delayed effects (during weight regain). Furthermore, it has been shown that SRT preferentially mobilizes the visceral and subcutaneous adipose tissue in the abdominal region [31,

38, 61, 105]. This kind of training procedure improves insulin-stimulated glucose uptake in patients with impaired glucose tolerance or T2D [41]. Subsequent increases in muscle mass, may regulate glucose levels and insulin responses to glucose load and therefore, improves insulin sensitivity [22, 132]. Also, high-intensity SRT decrease glycosylated haemoglobin (HbA1c) levels in diabetics, regardless of age [13, 127]. In addition, SRT is considered a potential coadjuvant to pharmacotherapy for the treatment of metabolic disorders, by decreasing some major risk factors of metabolic syndrome [46, 132].

During the first two weeks of SRT, intensity should be kept to an adaptive level so that patients learn the exercise techniques and their muscle mass would probably not increase. From the third week, the objective of the training is hypertrophy [159]. Participants should start with three sets per muscle group per week, on 3 non-consecutive days of the week. One set should consist of 10–15 repetitions corresponding with 60-70% one repetition maximum lifting weight per 2-3 sessions per week, are likely to be beneficial for maximizing the health effects of increased skeletal muscle mass [155]. The number of training sets for each muscle per week should be increased progressively every four weeks by one set to a maximum of 10 sets per week. The SRT program should consist of exercises for all major muscle groups [132, 142].

### ***2.3 Pharmacological treatments***

If the goal of weight loss has not been achieved after six months of good adherence to a therapy combining diet and physical activity, prescribing a drug treatment can be considered, always with some limitations and considerations [45].

Regarding the pharmacological therapy, one may mention the appetite suppressants, the food absorption/digestion blockers and the stimulators of thermogenesis [16, 82]. There is a long list of prospective drugs, including tesofensine and agonists and antagonists of satiety-inducing peptides and orexigens respectively, confirming a potential bright future for the treatment of the pandemic of obesity [119]. Nevertheless, they all entail well-known adverse effects and some of them show a very doubtful benefit/risk rate. Some other non-pharmacological alternative products or plants have been considered, but none of them has proved a long-term efficacy and/or safety [42, 107]. Indeed, in Europe the only accepted pharmacological treatment is the prescription of Orlistat, an inhibitor of lipase, combined with a low-fat diet [119].

## **2.4 Bariatric surgery**

At last, surgery may be an effective long-term treatment of morbid obesity, by reducing some clinical manifestations associated with obesity [88]. This approach could be indicated in subjects with BMI >40 kg/m<sup>2</sup> or BMI >35 kg/m<sup>2</sup> in the presence of comorbidities or with an inadequate metabolic control [117]. Diabetes is the fastest comorbidity corrected after bariatric surgery, achieving significant improvements in glycaemic control or eradication of the disease between 80-95% in 10 years [23, 37]. This surgery entails serious postoperative complications directly related with the severity of the obesity; also male gender and increasing age were globally associated with an increased risk of complications [140].

## **3. Hypoxic therapy and its applications**

One of the alternatives to address high prevalence diseases seems to be hypoxic therapy; which is commonly used in medical practice nowadays and well positioned in the field of traditional/alternative medicine, hypoxitherapy. The question remains open whether hypoxia or re-oxygenation is the responsible for the formation of adaptive signals and what the functional significance is. Experimental studies have not been appropriately focused on pheno-and genotypic features of the body response to hypoxia. Until now, what it is known is that appetite is suppressed, and a percentage of body mass is lost at high altitudes [126, 156]. Furthermore, oxygen variations in the organic system produce changes in body composition [111]. These findings can be of great interest for the treatment of obesity. Therefore, this review will focus on methods of hypoxia and their potential applications.

### **3.1 Methods of hypoxic exposure and of hypoxic training**

In general, there are two types of hypoxia stimuli: 1) Intermittent hypoxic exposure (IHE): passive exposure to hypoxia lasting from a few minutes to hours that is usually repeated over several days. These intermittent hypoxic exposures are interspersed with exposure to normoxia or lower levels of hypoxia. IHE raises the question of the minimum duration of exposure to induce erythropoiesis. It has been suggested that 180 min of IHE daily are necessary to increase endogenous erythropoietin (EPO), but in the vast majority of protocols this appears to be inconsistent [19, 40, 75, 148]. Cerebral oxygenation decreases, whereas muscle oxygenation increases due to a greater ability to extract O<sub>2</sub> in order to

counteract reduced O<sub>2</sub> availability, as shown by a decreased deoxyhaemoglobin during heavy exercise [92], 2) Intermittent hypoxic training (IHT) consists of physical activity under hypoxic conditions (for short periods, and remaining at normoxic conditions for the rest of the time. This is another way to benefit from hypoxic stimulus without undergoing the detrimental effects of a prolonged exposure to hypoxia. This method induces specific molecular adaptations at muscular level that do not occur in normoxic conditions [116, 148].

Several methods of IHE and/ or IHT are currently performed by elite athletes: traditional “live high-train high” (LHTH), “live low-train high” (LLTH), “live high-train low” (LHTL) or by using supplemental O<sub>2</sub> when training in altitude (LH + TLO<sub>2</sub>) [148]. More recently, the interest of intermittent hypoxic methods has been investigated: IHE and IHT. The technological development of various hypoxic devices has also made possible to combine these methods [143].

In spite of the substantial differences between these forms of hypoxic training and/ or exposure, all these methods have the same goal, inducing physiological adaptations and enhancement of athletic performance [158] (Table 1).

The experimentally used strategies differ greatly in cycle length, the number of hypoxic episodes per day, and the number of exposed days. Thus, protocols vary from those that examine the effect of as few as 3–12 relatively short (2–10 min) bouts of hypoxia interspersed with 2 to 20 min episodes of normoxia on a single day [15], to those that examine longer daily exposures (1–12 h) over periods ranging from 2 to 90 days [19, 143], and those that consider short sinusoidal cycles of hypoxia/ normoxia (30–90 s) 7–8 h daily for 30–70 days [75]. Regardless of the schedule, the compelling outcome is that these repeated episodes of hypoxia elicit persistent changes in a variety of physiological responses [27, 58, 92, 122, 124].

### **3.2 Intermittent hypoxia and applications in health, physiological and pathophysiological states**

Certainly, there are adaptations to chronic hypoxia that are not necessarily beneficial. Chronic intermittent hypoxia significantly increases right ventricular heart mass [25], it has been occasionally associated with pulmonary vascular remodelling and with pulmonary hypertension [96]. A number of investigations and trials identified physiological effects on different cells, tissues and systems and respiratory disorders (Table 2).



### ***3.3 Intermittent Hypoxic Exposure (IHE)***

A significant percentage of the obese population suffers from obstructive sleep apnea (OSA) [94]. OSA is characterized by transient periods of oxygen desaturation followed by re-oxygenation, and is a major cause of systemic damage (oxidative stress, inflammation, sympathetic activity, vasculature remodelling and endothelial dysfunction) and/or protective (preconditioning-like cardioprotective) effects. This condition (OSA) has rarely been given importance in obese patients, although many OSA bearing subjects are obese, and obesity is an independent risk factor for many comorbidities associated with OSA [104]. Thus, it has been speculated that the chronic intermittent hypoxia caused by OSA in obese patients might be one of the underlying mechanisms in the morbi-mortality paradox of obesity. Moreover, OSA increased plasma neuropeptide Y levels, an appetite-stimulating peptide, independently of body weight [136]. This is a controversial feature since risks concerning endocrine health caused by sleep breathing disorders threaten to exacerbate the already compromised metabolic regulation and control of normal body weight in this obese population [102]. Experimental evidence from human models is required to elucidate such risks and to facilitate clinical decisions about whom to treat.

Interestingly, IHE induces lessening of bronchial spasm, more uniform lung ventilation and increases ventilation sensitivity to hypoxia [9].

Watson et al [152] explored genetic contributions of sleep disturbances in over 1800 twin pairs and found that 10% of common additive gene effects accounted for 10% of the phenotypic association between obesity and insomnia. Similar gene model fitting studies are needed to assess the genetic contribution of reduced sleep to BMI [94].

Sleep intermittent hypoxia debt exerts profound effects on metabolic hormones and molecular signatures [4]. These changes are accompanied by an increased food intake and energy storage, which potentiates the development of insulin resistance, T2D, hypertension and heart disease [113]. Recent reports provide new insights about possible mechanisms to explain OSA effects on lipid and glucose metabolism by inducing sympathetic activation, increasing systemic inflammation, stimulating counter-regulatory hormones and fatty acids, or causing direct pancreatic beta-cell injury [44].

Lately, it has been shown that hypoxia through factor HIF-1 expression changes, helps to regulate mitochondrial function. It is interesting to note that there are often defects in the mitochondrial function in many pathophysiological processes, which seem to improve with the stimuli of IHE [130].

### ***3.4 Intermittent Hypoxic Training (IHT)***

The potential applications of IHT in health and in various pathophysiological states are numerous [9, 76], since it could be a non-pharmacological method for enhancing some physiological functions and rehabilitation in patients with different chronic diseases [63]. Hypoxic training increased physical work capacity about 5% in the healthy elderly subjects and 10% in elderly subjects [155].

The ventilatory response to hypoxia increases during submaximal exercise, and induces a smaller hypoxic pre-acclimation decrease in arterial oxygen saturation (SpO<sub>2</sub>) [54, 110]. Furthermore, IHT has been shown to raise baroreflex sensitivity to normal levels and to selectively increase hypercapnic ventilatory response, total exercise time, total haemoglobin blood levels, and lung diffusion capacity for carbon monoxide in bronchial asthma and chronic obstructive pulmonary disease patients [149].

Some favourable effects of IHT are conditioned by triggering a long-term adaptation to hypoxia, leading to positive changes in internal organs. These phenomena have been well studied in young and middle aged people. In the cardiovascular systems, reduced sympathetic-adrenal reaction to stress and the blood flow along vessels of microcirculatory system was improved at the expense of increases on the diameter of arterioles [63]. In elderly people IHT, had a positive influence on the antioxidant system, along with an activation of the antiradical defence enzymes, and a decrease of lipid peroxidation products in tissues [18].

A few studies have investigated the influence of various IHT regimens on inflammation-related cytokine secretion caused by acute exercise [151]. Severe IH or moderate IH (12-15% O<sub>2</sub>, 1 hour/ day, 5 days/week for 8 weeks) ameliorated the effects of severe exercise on IL-1 $\beta$  secretion. A possible reason for this outcome is that training increases circulatory anti-inflammatory cytokine levels, such as IL-6 and IL-10, with inhibited production of IL-1 $\beta$  during severe exercise [150].

The neuroprotective role of EPO has been proven [129] by showing that normobaric hypoxia reduced the risk of cardiovascular disease [99, 155 164], improved the respiratory function [68], produced CNS protection [89] and basal metabolism reprogramming [7]. On the other hand, it is known that

training in hypoxia and in normoxia reduced the circulating concentration of free fatty acids, total cholesterol and HDL cholesterol. However, it did not reduce the levels of homocysteine, an acidic molecule implicated in heart disease [98].

At the same time, it has been demonstrated that IHT may normalize blood pressure in hypertensive patients [123, 124]. Moreover, it has been shown that systolic blood pressure is reduced after IHT, causing a hypotensive effect [43]. Thus, it has been confirmed that physical exercise in hypoxia decreases the risk of cardiovascular disease [12, 24].

On the other hand, aging is associated with changes in breathing regulation, particularly, in respiratory sensitivity to IHT. One theory of aging holds that reactive oxygen species play a key role in this process. These species have also been implicated in the carotid body O<sub>2</sub> sensing. Studies have investigated hypoxic ventilatory responses (HVR) and antioxidant enzymes activity in healthy young and elderly people in adaptation to IHT [76]. The elderly demonstrated decreased HVR and blood catalase (CAT) activity on a background of strong negative correlation between the levels of end-tidal CO<sub>2</sub> tension and superoxide dismutase (SOD) activity. The adaptation to IHT resulted in increased HVR and SOD activity in both groups [76].

Furthermore, results of clinical studies have shown that IHT in elderly patients could be useful and valuable, leading to reduction in clinical symptoms of angina and duration of daily myocardial ischemia, normalization of lipid metabolism, optimization of oxygen consumption, improvement of vasomotor endothelial function due to increased formation of nitric oxide, normalization of microcirculation and increased exercise tolerance [77, 78].

### **3.5 Intermittent hypoxia and insulin sensitivity**

Acclimation to an altitude of 4000m in IHE has been found to decline blood glucose, parallel to a higher glucose turnover, both at rest and during exercise [21]. This increased muscle uptake of glucose is accompanied by enhanced insulin sensitivity [11, 131]. Likewise, it was reported that, in high altitude (2600m) the HbA1c decreased significantly in obese people four weeks after the altitude stay [84].

An increase in body fat is linked with a decline in insulin sensitivity in both obese and elderly individuals, and a recent study showed that acute hypoxic training improved glucose tolerance, and that combined exercise in hypoxic state further ameliorated insulin sensitivity in T2D [87]. Other trial

demonstrated that IHE glucose tolerance enhancement four hours after exposure can be attributed to improvements in peripheral insulin sensitivity in sedentary males with T2D. Therefore, it may improve short-term glycaemic control [85].

Similar to the effects of exercise, increased epinephrine during IHE, which was reported in healthy humans may have contributed to glycogen utilization via increases in cyclic adenosine monophosphate concentrations, potentially leading to post-treatment increased insulin sensitivity [72]. Similarly, it has been described that both IHE and IHT programmes carried out in hypoxic conditions increased glucose transporter GLUT-4 levels [33].

Hypoxia and exercise have shown an additive effect on insulin sensitivity [87], suggesting that insulin signalling and insulin-dependent glucose transport, might have been up-regulated following hypoxic exercise [33, 34]. This additive improvement could also be attributed to an increase in the relative intensity of the practised exercise in hypoxia [56]. To sum up, acute hypoxic exercise could improve short-term glycaemic control in sedentary individuals with insulin resistance.

### **3.6 Intermittent hypoxia training and molecular mechanisms**

In recent years, certain proteins involved in the process of sensing and regulating the concentrations of oxygen in tissues have been described. Such proteins may have a predominant role in the hypoxia inducible factor (HIF) and in the hydroxylase regulation [92].

There is a large demand of oxygen during physical activity, regardless the type and intensity of exercise [73]. In spite of that, there is a general condition of ischemia-reperfusion due to the high voltage generated by the muscles during maximal or submaximal contractions. In other words, there are cycles of hypoxia-hyperoxia [35]. Physical activity leads to an increase in oxygen free radicals, but it is not entirely clear whether the phenomenon linked to free radicals increase is hypoxia or hyperoxia. However, it seems that hyperoxia is the most likely factor [157]. Other researchers have suggested that free radicals are possible mediators of the response to hypoxia [3]. However, it has not been possible to fully understand the interaction between hypoxia-hyperoxia, free radicals, HIF and intracellular signalling, neither in the skeletal muscle, nor in other cells yet [157].

There are reports showing that after six weeks of physical training, mRNA levels of HIF-1 rise (between 58-82%) only in subjects who trained in hypoxic environment (3850m), both at low and at high

intensity, compared to other groups who trained in normoxia at low and high intensities of exercise [58, 148]. These studies suggest that there are no HIF-1 increases in normoxic environments and that in hypoxia only the effects achieved due to physical training in normoxia are relevant.

On the other hand, mRNA levels of phosphofructokinase gene, a key enzyme in glycolysis, are increased as it has been shown to occur only in high-intensity IHT [148]. This finding that the intensity of exercise in hypoxia may have different effects at the metabolic level, and that might be related to variations between the hypoxia and the hyperoxia produced, required to be further clarified.

There is an extensive list of genes regulated by hypoxia [122], many of which are involved in growth and differentiation [153]. Furthermore, it is also known that exercise regulates the expression of many genes, but the mechanisms are often unknown and the genes controlling this phenomenon (and favour cardiovascular health) are still under investigation. Regular bouts of physical activity may cause changes in gene expression that accumulate over time and, ultimately, affect phenotypes, such as body weight, blood lipid profile and tumour development. Furthermore, acute activity may affect gene expression and phenotypes differently depending on whether the individual is regularly inactive or active [128]. Knowledge of these genes would help to understand, for example, how exercise leads to muscle hypertrophy. This outcome suggests that further studies are needed to evaluate the relationship between hypoxia and the genes regulated by the HIF-1.

Adaptations to exercise or hypoxia are increasingly being applied preventively or as a treatment to different pathophysiological situations and, therefore, they begin to have global significance [27]. HIF expression is upregulated with exercise and it might be an important factor that regulates adaptive gene responses to exercise [86]. It is therefore, important that only high-intensity training under hypoxic conditions leads to adaptations that include regulation and elevated HIF-1, as a mechanism to compensate the reduced availability of oxygen. It seems that intense muscle contraction and oxygen deficiency are essential to generate some adjustments. Thus, it has been noted that the muscle generates a series of major adaptations when training in hypoxia [58].

However, at the present time there is scarce information about how different intensities and kinetic contraction of muscle affect activation of HIF-1 and other proteins [58]. The only available information is that HIF-1 average life is less than five minutes [55]. For this reason, training protocols in intermittent hypoxia are usually of 5'-5', hypoxia-normoxia. This situation may explain why training at sea level is not enough to alter the HIF-1 cascade [86]. Although it may be surprising, the studies

developed by Lundby and his colleagues indicate that regular training reduces the hypoxia observed after acute exercise. Therefore, there are no major changes in the HIF-1, as they existed at the beginning of the training [100]. Although cellular hypoxia persists, the HIF-1 is not affected equally and, as a consequence, it becomes tolerant to hypoxia. According to Lundby and colleagues (2006), there are other mechanisms explaining the effects produced by intermittent chronic training in hypoxia. Nitric oxide (a potent vasodilator) may be involved in this adaptive mechanism, but no studies proving this hypothesis have been found. Oxygen free radicals may be the other factor involved in this mechanism [29], since it is known that they increase in hypoxia and that, at the same time, they are mediators of muscular adaptations [57, 58, 64].

### **3.7 Intermittent hypoxia and exercise: possible applications in obesity**

Oxygen plays an important role, as electron acceptor in the long chain of reactions produced to obtain energy in the form of ATP, both in humans and in other higher organisms. Low oxygen levels lead to tissue hypoxia; high oxygen levels lead to inflammation hyperoxia [140]. The two states entail different effects, and body composition changes may occur because of them [111]. Studies show that appetite is suppressed and that there is body mass loss at high altitudes [126, 156]. Similarly, it has been noted that oxygen variations in the organic system produces changes in body composition [111].

Acute exposure to hypoxia, both in humans and in rats, produces an increase in blood serotonin levels [51]. Moreover, hypoxia causes an increase in the adrenergic system [6, 159]. Food intake, protein intake and carbohydrates selection, as well as body weight, are partially regulated by serotonin, a compound that after administration to rats produces anorexia [51].

Rats submitted to a high altitude (Cerro de Pasco, Perú, 4340 m) for up to 84 days showed a physiological adaptive response with decreased body weight gain (-15%), increased right ventricle weight (+100%), and increased hematocrit (+40%) compared with sea level animals. These classical parameters of adaptation to high altitude were accompanied by an increase in heart mitochondrial enzymes: complexes I-III activity by 34% and mitochondrial nitric oxide synthase (mtNOS) activity and expression by more than 75% [160].

Similarly, in obese subjects it is known that leptin is involved in regulating body weight and controlling energy resources [12, 139]. It has been observed that acute hypoxia decreases blood glucose

and basal leptin levels [72]. These observations allow us to consider the hypothesis that IHE defined as situations of exposure to low concentrations of ambient oxygen alternating with periods of normoxia [61] may result in decreased appetite and fat loss, which might be of interest for the treatment of obesity. On the other hand, IHE can reduce not only body weight by increasing leptin concentration and enhancing liver leptin expression, but also decrease serum glucose, blood cholesterol and meanwhile prevent steatosis in liver cells effectively, in obese mice [83]. Moreover, it has been described that obese individuals staying one week at 2650m of altitude (without exercise) lost weight and reduced blood pressure [84]. It can be hypothesized that adding exercise to the IHE stimulus could result in further cardiovascular changes and in an improved health and body composition.

Physical activity in hypoxia increased the number of mitochondria, the capillary density [107], and muscle oxidative enzymes, and changed energy production pathways with potential for an increase in lipolysis [116]. Adaptive responses to the respiratory tract and cardiovascular system are produced and, at the same time, the mitochondrial efficiency, pH / lactate regulation [81, 164], and physical performance are increased [17, 108, 143].

There is scientific evidence suggesting that a lower degradation of hypoxia inducible-factor alpha (HIF-1 factor  $\alpha$ ) caused by conditions of hypoxia, along with physical activity, can prove very effective and be part of major medical applications in the long-term [27]. After 6-week training in IH, there was a dramatic increase in mRNA concentrations of many genes, such as HIF-1 $\alpha$  (+104%), glucose transporter-4 (+32%), phosphofructokinase (+32%), citrate synthase (+28%), carbonic anhydrase-3 (+74%) or monocarboxylate transporter-1 (+44%) [148]. These results demonstrated that training in IH at high intensity is probably a good way to favour oxygen utilization within the muscle.

Thus, the hypoxic stimulus in addition to diet and exercise can be another powerful incentive to lose weight, which may have effects in the mid-long term (unlike diet therapy and physical activity alone), since effects of hypoxia are maintained for one month post-treatment, due to increases in basal noradrenalin and other possible changes that remain to be clarified [84].

### **Proposed new hypoxic training model**

The Intervalic Hypoxic Training protocol comprises repeated exposures to hypoxic air breathing, altered with breathing environment (normoxic) air. During the training course, **strength-resistance exercises (20')** and **high intensity aerobic exercises (30-40')** are performed. The hypoxic air decreases gradually from 16,7-11,2% (SpO<sub>2</sub>, 89-75%) in order to provide a step-wise adaptation and to avoid over-training. Sessions are repeated 3-4 times per week for periods of 3-6 weeks, and session duration is in the range of 40-60' (Table 3).

The physiological response is monitored by a pulseoxymeter, a device that measures SpO<sub>2</sub> and heart rate (HR). Other physiological parameters can also be monitored, for instance blood pressure and cardiac activity by an electrocardiogram. Monitoring of the user's physiological parameters allows us to avoid the undesirable effects of over-dosing. Advanced bio-feedback controlled hypoxicators are capable of adjusting the oxygen concentration in the inhaled hypoxic air automatically, compensating for individual variability [15, 143].

**Hypoxia Stimulus charge** (HSc= SpO<sub>2</sub>% x time in minutes) parameter provides an objective measure of the hypoxic stress delivered during the IHT session, compared to simple recording of the inhaled fraction of oxygen (FiO<sub>2</sub>). HSc provides the dosage received by a person at the end of the session and compensates for individual variability in scientific studies, to ensure that subjects are correctly controlled for individual exposure. It is accepted that tissue hypoxia develops only when SpO<sub>2</sub> drops to 90% or below. This is due to the oxyhaemoglobin dissociation curve. SpO<sub>2</sub> above 90% produce very little effects or decrease of arterial partial pressure (PaO<sub>2</sub>). Due to all these data, our protocol of IHT comprises ranges of SpO<sub>2</sub> between 75 and 89%.

### **Concluding remarks**

High intensity exercise and intermittent hypoxia in the short and long term may have important medical applications in pathophysiological problems with metabolic-muscular disorders, such as obesity. However, nowadays there are few studies and clinical initiatives to use stimuli of intense physical activity or intermittent hypoxia, with the uncertainty that patients may not bear this type of training or that the training may not result very pleasant for them. Although it is not possible to stay at high altitude and to remain there in many countries - due to orographic conditions-, current technology allows to simulate



the effects of altitude (hypoxia) at sea level, through instruments that reduce the content of oxygen on inspired air (normobaric hypoxia) (Figure 1).

Intermittent hypoxia may have many applications for improving cardiovascular health, the great public health concern in Western societies [24]. Similarly, stays in altitude or hypoxic situations may help to lose weight and normalize arterial blood pressure. Summing up, the IHT is a non-pharmacological method, for enhancing the functional resources of a healthy organism and the rehabilitation in patients with different chronic diseases. The IHT stimulus could be of great tool and very practical for clinical use in obese patients by reducing appetite and regulating fat deposition.

#### **Conflict of interest statement**

The authors declare not having any personal or financial support or involvement with organizations with financial interest in the subject matter or any actual or potential conflicts of interest.

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**Table 1. Different methods of hypoxic exposure and of hypoxic training**

<b>Methods of Hypoxic Exposure and/ or Training</b>	<b>Hypoxic exposure, passive (IHE)</b>	<b>Hypoxic training, active (IHT)</b>
	IHE + normoxia	LL-TH
	IHE + supplemental O <sub>2</sub>	IHIT
	LHTL: Hypoxic generation method: 1) natural altitude (IH), 2) nitrogen dilution (NH), 3) Oxygen filtration (NH)	AHCT  LHTH (IHE+IHT)
<b>Examples</b>	1) 5 - 5' environment air (FiO <sub>2</sub> = 20,5%) - hypoxic air-gas (FiO <sub>2</sub> = 9-12%)/ 60-180' per day/ 2-4 weeks [15, 68]  2) 8-12 h to sleep (FiO <sub>2</sub> = 11,2-15,6%) per day/ 3- weeks [15, 158]	1) 90-120' environment air (FiO <sub>2</sub> = 16,7-14,6%) [108] or altitude (2000-3000m) low-moderate intensity/ 4-5 sessions/week/ 3-8 weeks [17]  2) 30-60' ambient air (FiO <sub>2</sub> = 16,7-11,2%) [57, 100, 143] or altitude (2000-5000m) high intensity exercise/ 2-4 sessions week/ 3-6 weeks [19, 75]
<b>Usefulness</b>	Pre-acclimation in climbers [17]  Heart [24], respiratory [9,68, 69, ] and nervous [129, 161, 162] diseases  Health field in general [15, 55, 60 123]	Performed by athletes [17, 19, 57, 75 81, 108, 116, 143, 158, 163]  Pre-acclimation in climbers [54]  Metabolic and cardiovascular risk [12, 24, 29, 43, 63, 77, 162]  Glycaemic control [13, 33]  Antioxidant system [18, 147]

NH: Normobaric Hypoxia; HH: Hypobaric hypoxia; LH: Living High; TH: Training High; TL: Training Low; LHTL: Living High Training Low; LHTH: Living High Training High; LL: Living Low; IHE: Intermittent Hypoxic Exposure; IHT: Intermittent Hypoxic Training; IHIT: Intermittent Hypoxic Interval-Training; AHCT: Altitude-Hypoxic Continue Training.

**Table 2: Compensatory mechanisms and responses to hypoxia**

<b>Respiratory system</b>	<b>Cardiovascular system</b>	<b>Cellular and metabolic</b>	<b>Regulation of body weight</b>
Hiperventilation [155]	Increases basal and maximal heart rate [6, 52]	HIF-1 factor and VEGF expression [122, 153]	Decreases basal leptin levels [72]
Increases lung diffusion capacity for CO and O <sub>2</sub> [149]	Increases peripheral vasodilation [63]	Angiogenesis [28, 47]	Increases adrenergic system [85, 159]
Increases the CO <sub>2</sub> reserve in sleeping [69]	Increases diameter of arterioles [63]	Increases glycolytic enzymes and number of mitochondria [46]	Basal noradrenaline remains high post treatment [84]
Decrease in SaO <sub>2</sub> was smaller [110]	Increases Hg-O <sub>2</sub> affinity [32]	O <sub>2</sub> , Fe and glucose conveyors [109]	Increases blood serotonin levels [51]
Ventilatory response during exercise increased [54]	Normalises blood pressure [12, 124]	Improves insulin sensitivity [87]	Appetite is suppressed [126, 156]
Improves respiratory function [68]	Cardiovascular protection [155, 163]	Increases glucose transporter GLUT-4 [33, 34]	Increases body weight loss [84]

**Table 3. New method of IHT (proposed by the authors of this review)**

<b>Method</b>	40-60'environment air ( $FiO_2 = 16,7-11,2\%$ ) or altitude (2000-5000m) / sets of <b>strength-resistance exercises (20')</b> + <b>high intensity aerobic exercise (30-40')</b> /3-4 sessions week/ 4-6 weeks	
Sets and recovery times	Exercise between sets: 20''-180'' Recovery between sets: 2-6'	
Target $SpO_2\%$	Exercise between sets: 75-80% Recovery between sets: 80-89%	
Hypoxia Stimulus charge (HSc)	HSc= $SpO_2\% \times t$ (time in minutes) 3400-4800 units	
Total sessions	16-24	
<b>Applications</b>	<u><b>High prevalence diseases:</b></u>  <b>Obesity</b>  Hypertensive patients  DT2  OSA	<u><b>Sports:</b></u>  Elite athletes (sport specific exercises)  Pre- acclimation in climbers



**Figure 1. Normobaric-Hypoxic tent equipped for research [143] and used to trained climbers for an Everest expedition, 2011 (unpublished results).**